Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
20 + UP TO 21 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Wt.(lbs)	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments **Birth Control:**_____ **Menarche:**_____ **LMP:**_____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT **Age appropriate?** [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT **Referral indicated?** [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
Pelvic & Pap Smear		

LAB/SCREENING

Pregnancy Test		
Screening for Syphilis, Chlamydia, Gonorrhea		
Tuberculin Test		
Hct./Hgb.		
Urinalysis		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Immunizations current? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Dental Care
[ ] Good health habits and self-care
[ ] Social interactions
[ ] Pregnancy prevention
[ ] Educational activities
[ ] Physical activity
[ ] Smoking, alcohol, drugs
[ ] Counseling about sexual activity

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Gynecology
[ ] Prenatal Care [ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No